WELCOME TO SHEA PHYSICAL THERAPY

Patient Name: _____ A.K.A _____ Today's Date: _____

Address: _____ City/State/Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

E-Mail Address: _____

Social Security Number: _____ Date of Birth: _____ Age _____

Male / Female Married / Single / Widowed Which hand is your dominant hand? Right / Left

Employer: _____ Work Phone: (____) _____

Address: _____ City/State/Zip: _____

Race: ___American Indian/Alaska Native ___Asian ___Black/African American ___White
___More than one race ___Native Hawaiian ___Pacific Islander ___Unreported/Refused to report
Ethnicity: ___Hispanic/Latino ___Non-Hispanic/Latino ___Unreported/Refused to report

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PRIMARY Insurance Name: _____

Date of Accident: _____ Date of Surgery: _____

Guarantor's Name: _____ Relationship _____

Social Security Number: _____ Date of Birth: _____

Guarantor's Address: _____ City/State/Zip _____

SECONDARY Insurance Name: _____

Guarantor's Name: _____ Relationship _____

Social Security Number: _____ Date of Birth: _____

Guarantor's Address: _____ City/State/Zip _____

Referring Doctor's Name: _____

IN CASE OF EMERGENCY CONTACT: _____

Address: _____ City/State/Zip: _____

Phone Number: (____) _____ Relationship: _____

PLEASE ANSWER ALL OF THE FOLLOWING:

Briefly describe your injury: _____

Have you had surgery? _____Yes _____No If yes, when?_____

Are you taking medication for:

___Pain ___Diabetes ___Blood Pressure ___Cholesterol

___Heart ___Thyroid ___Vertigo ___Blood Thinner

___Rheumatoid Arthritis Other:_____

In general, you would rate your overall health as: __Excellent __Good __Fair __Poor

Have you ever experienced heart problems, including heart surgery?

_____Yes _____No

Do you have a pacemaker? _____Yes _____No

Have you ever tested positive for tuberculosis? _____Yes _____No

Do you have diabetes? _____Yes _____No

Do you have a history of seizures? _____Yes _____No

Do you have a history of dizziness? _____Yes _____No

Do you have a history of hypertension? _____Yes _____No

Do you have any joint problems, muscle problems or injuries? _____Yes _____No

If yes, please explain:_____

Are you allergic to Latex? _____

Do you have neck problems including neck surgery? _____Yes _____No

If yes, please explain:_____

_____

What are your hobbies/sports?_____

Are you able to perform them at this point? _____Yes _____No

If employed, are you working at this time? _____Yes _____No

If yes: _____Light Duty _____Modified Duty _____Regular Duty _____Not employed

Were you seen by a therapist or a chiropractor regarding this injury before your doctor referred you to us? _____Yes _____No

If yes, how many weeks were you treated?_____

_____ _____

Signature Date

PATIENT HISTORY – LYMPHEDEMA

NAME: _____ DATE: _____

DOB: _____ AGE: _____ REFERRING PHYSICIAN: _____

MEDICAL HISTORY: (Please check all that apply)

O Diabetes O Vascular problems O High blood pressure O Heart disease

O Cancer	O Broken bones	O Pacemaker	O Pregnant
O Allergies	O Thyroid problems	O Lung	O Kidney problems
O Trauma	O Metal implants	O Other	

Please explain any checked items: _____

_____

_____

Medications: (name dose and frequency) _____

_____

_____

Medication Allergies: _____

Over the counter supplements: _____

Lymphedema of: □ Right Arm □ Left Arm □ Head/neck
□ Right Leg □ Left Leg □ Genital □ Other _____

Breast surgery: □ Right side Yr.____ □ Left side Yr._____ □ Both Yr_____
□ Lumpectomy □ Simple/total mastectomy □ Modified/ radical
□ Axillary node dissection □ Sentinel Node Biopsy

Abdominal Surgery: □ Pelvic resection (date) _____
□ Hysterectomy (date) _____
□ Other abdominal surgeries, please list

_____

Prostate Surgery: (date) _____

Head and Neck _____ Yr _____ Radiation?_____

Other surgeries, please list: _____

_____

Have you had : □ Chemotherapy # of treatments:_____ Year:_____
□ Radiation # of treatments: _____ Year: _____
□ Infection(s) Antibiotics: _____ Hospitalized: _____

_____

1. Do you know how your lymphedema developed? If so, describe how and why: _____

_____

2. How long have you had lymphedema? _____

3. Have you had previous intervention for your lymphedema? ☐ Yes ☐ No
   - ☐ Pump What kind? _____
   - ☐ Garments What type? _____
   - ☐ Diuretics _____
   - ☐ Other: _____

4. Do you have any pain associated with your lymphedema? ☐ Yes ☐ No
   Duration of pain: ☐ Constant ☐ Intermittent
   Severity of pain: (circle one) No pain (0) 1 2 3 4 5 (Severe pain)
   What kind of pain do you feel? _____
   What relieves your pain? _____
   What aggravates your pain? _____

5. Do you wear a compression sleeve/garment at present? ☐ Yes ☐ No
6. Have you ever leaked lymph fluid? ☐ Yes ☐ No
7. Have you ever had open sores on your affected limb? ☐ Yes ☐ No

8. What tests/studies have been done for your lymphedema? _____

9. Have you traveled outside of the United States? ☐ Yes ☐ No
10. Do you exercise regularly? ☐ Yes ☐ No
11. Do you smoke or drink? ☐ Yes ☐ No

12. What is your occupation? _____

13. What is your daily lifting activity? ☐ Light ☐ Moderate ☐ Heavy

14. What can't you do because of your lymphedema? _____

15. Please list your hobbies and interest and if they have been affected by your lymphedema. _____

16. Do you feel tired all the time? ☐ Yes ☐ No

17. Has your lymphedema affected any of your relationships? ☐ Yes ☐ No

18. What are your expectations from your treatment? _____

19. Other concerns, comments, questions: _____

BODY PICTURE CAN BE USED HERE

Patient's Signature _____ Date _____

Therapists Signature _____ Date _____

04/04

LYMPHEDEMA TREATMENT CONSENT

NAME: _____

Successful treatment of lymphedema requires commitment and dedication of the patient and therapist. It is to be understood that this program is ***not a cure*** but a maintenance program and you will be responsible for keeping your condition under control for the rest of your life. Reduction of edema not only improves the patient's quality of life, but also decreases the incidence of severe secondary infections. If you are treated (*name of facility*), you will be required to follow a specific program at the office and at home.

This program consist of:

1. Daily/weekly visits for evaluation, treatment, and measurements by the therapist.
2. Massage /manual lymph drainage which will include the chest and groin.
3. Bandaging of the limb 20-22 hours a day.
4. Self-bandaging on weekends. (You and your family will be instructed in self-massage and self bandaging)
5. Therapeutic exercises to accelerate lymph flow.
6. Instruction in a home maintenance program.
7. Instructions on skin care.

Bandages and garments (unless covered by your insurance company) need to be paid for in cash, check or credit card.

Please note that non-compliance or inconsistent compliance in the above outlined program may lead to discharge.

Are you prepared to follow such a program? Yes____ No____

This consent form has been explained to me and I certify that I fully understand its contents.

_____
(Print Name)

_____ _____
(Patient's Signature) (Date)

_____ _____
(Witness) (Date)

re:04/04

SHEA PHYSICAL THERAPY LYMPHEDEMA SERVICES

NO SHOW POLICY

Thank you for choosing our practice for your Lymphedema needs.

We have made a few changes with our office policies, Effective May 1st, 2020.

If you have any questions, please feel free to give our office a call (361)994-5224. Our goal at Shea Physical Therapy is to best serve our patients with quality care, as well as in a timely manner.

In order to do so we have established a **"NO SHOW" policy**.

When a patient fails to show up to their scheduled appointment or cancel within 24hrs, our valuable time and resources are missed. Most importantly, our ability to care for a patient in need is missed. When we are notified that you are unable to make your appointment, it allows our office staff to schedule another patient needing care.

If you fail to notify our Occupational Therapist, Anita Spreen, a "no show", or "late cancellation" fee of $50.00 will be assessed for the missed appointment.

Do understand all fees accumulated are not your insurance's responsibility and will be billed directly to you. These fees will also be due upon your next scheduled appointment. Also, please be advised that multiple "NO SHOW'S" without adequate reason, may result in termination of care.

What is considered a no show: If you are scheduled and fail to cancel your appointment 24hrs prior to your scheduled appointment time and/or arrive 15 minutes AFTER your appointment time, you will be considered a No Show.

Thank you for your understanding.

Patient name (PRINTED)_____

Signature_____

Date:_____

SHEA PHYSICAL THERAPY/HAND THERAPY SERVICES

Policy for Cancellations and No Shows

These policies have been developed to assist our therapist in scheduling their patients efficiently so that each of you will be given the appropriate time when you arrive for your treatment session. We appreciate you assisting us in the matter of **cancellations** and **no shows** for our operation.

1. We will request a 24 hour notice in the event of a cancellation. It is the patient's responsibility, when you call in, to have an alternative time in mind that will ensure that you get in the full prescribed number of treatments that week whenever possible.

2. Please understand that when you do not show, three people are affected:

   a) First the patient because you do not get the treatment you need as prescribed by the doctor.

   b) Second, the therapist who now has a space in their schedule since the time was reserved for you personally.

   c) Third, another patient could have been scheduled for treatment if there had been proper notice.

   Should you have to reschedule, please understand that you may need to see a clinician other than the one who normally treats you as a result of rearranging the appointment period. All of our clinicians are experienced professionals, and they will study your chart, so you will be in good hands. You will return to the original clinician in the next regularly scheduled visit.

Should you need to cancel or change an appointment, please contact our office directly; for Shea Physical Therapy (361) 994-5224 and for Hand Therapy Services (361) 992-1435. Again this policy is to assist our facility to offer you the patient a much more efficient operation. We strive to minimize the amount of wait time that you may have in our lobby by keeping our therapists on a regular schedule.

We look forward to having the opportunity to work with you and to assist you in your current therapy need.

Sincerely,

Daniel R. Shea, P.T
Shea Physical Therapy

Sheila Heflin, OTR, CHT
Hand Therapy Services

Patient Signature_____ Date_____

Consent for Treatment/ Privacy Policy/ Assignment of Benefits

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. On your initial visit the therapist will evaluate you as it relates to your diagnosis. Following the evaluation, a plan of care will be developed in cooperation with your physician. Risks, side effects, complications and benefits of treatment will be discussed with you. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills are handled.

EXPLANATION OF INSURANCE COVERAGE

Most insurance policies cover physical therapy, but this office does not ensure that yours does. Insurance policies can differ greatly in terms of coverage for physical therapy. Because of the variance of one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and we will bill your insurance company (ies) in a timely manner.

I. ASSIGNMENT OF BENEFITS

Authorization of payment: I hereby assign all benefits directly to Shea Physical Therapy. If my insurance carrier sends me payment for services incurred in this office, I shall send or bring the full payment to your office immediately upon receipt. I understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment in full.

_____ _____

Signature Date

II. SUMMARY OF BENEFITS

Deductible: $_____-has been met\not met $_____coverage %_____co-pay$_____

- Your insurance carrier(s) covers the following:
  _____Visit(s)/dollar(s) per calendar year. _____Procedure(s) per visit.
- The following services are not covered by your insurance carrier:

_____

- _____ Your insurance will not cover these services and you will be responsible for payment of the services you receive.

Terms of Benefits

This is a description of benefits, as given to us by your insurance company. This information is provided to you as a courtesy only. It is the patients responsibility to check with your insurance to verify benefits/coverage. Summary of benfits is not a gurantee of payment and is subject to change. I fully understand that any unpaid portion of services rendered is my responsibility. Quotes are an estimated calculation, according to the description of benefits given by my insurance company. I agree to the terms and conditions presented to me by Shea Physical Therapy. I acknowledge and accept the terms and conditions set forth in Sections I and II of this statement:

_____ _____

Signature Date

III. CONSENT FOR RELEASE OF INFORMATION

The undersigned authorizes the release of any personal health information required for treatment, payment or health care operations. This may include physicians, case managers, and insurance carriers or third party payers. Further, the undersigned releases Shea Physical Therapy to provide outside healthcare providers/services such information as is necessary to facilitate proper healthcare. In addition, the patient consents to the release of prior medical records from referring physicians, hospitals, case managers, or other entities, which have records necessary for proper evaluation and treatment of the patient. All other uses and disclosures will be made only with your written authorization. You have the right to revoke authorization for further uses and disclosures at any time.

IV. CONSENT FOR TREATMENT

I consent to rehabilitation and incidental medical services at Shea Physical Therapy. I understand the expected benefits, possible risks, side effects, complications and discomforts of my rehabilitation. I know and agree that Shea Physical Therapy is not responsible for lost or damage to personal valuables.

V. PRIVACY POLICY

Shea Physical Therapy will administer your records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. I have received a copy of the notice of privacy practices.

I acknowledge and accept the terms and conditions set forth in Sections III. IV. and V of this statement.

_____ _____

Signature Date

_____ _____

Witness' Signature (staff) Date

We hope this answers any questions you might have concerning the financial policies of this office. Once again we welcome you to our office and will be glad to answer any further questions you might have.

If the patient is a minor, or legally incapacitated, please obtain the signature of a parent or legal guardian.

SUPPLIES/HOME EQUIPMENT

Your insurance company may or may not cover certain supplies or home equipment issued to you by our facility. **Supplies** are those items required to carry out a specific treatment order (i.e. electrodes, lumbosacral rolls, instruction booklets, etc.). **Home Exercise Equipment** are those items which may be used to enhance your rehabilitation at home (i.e. theratubing, hand putty, weights, pulleys, etc.).

We try to purchase these items in bulk thus reducing the cost of these items. This savings is then passed on to the patients/insurance companies. We try to keep the pricing of these items extremely fair as we realize the purchase of these items may become the patient's responsibility.

You always have the right to choose whether or not you would like to personally purchase the equipment should your insurance company not cover those items. The supplies, however, are required for your treatment and will be your responsibility should your insurance not cover those items.

Please check with the front desk concerning your insurance coverage. An itemized list of equipment and prices will be shown to you so that you may decide if you would like to purchase the item.

If you have any questions, please do not hesitate to discuss with our office.

Thank you.

I have read and understand the above policy: _____
Signature

_____
Date

SHEA PHYSICAL THERAPY
HAND THERAPY SERVICES

January 1, 2020

To our Medicare patients:

MEDICARE BENEFICIARIES:

Effective January 1, 2020, Congress has permanently extended the current exceptions process for physical and occupational therapy. For the calendar year 2020 this amount is $2,080.00 for physical and speech therapy services combined and $2,080.00 for occupational therapy. Therapy claims for outpatient Medicare Part B services that go above $2,080.00 will require the use of a modifier for attestation that claims are medically necessary which may provide a higher threshold to $3,000.00.

We will work with you individually to assist in determining your benefits. We will be requesting you to sign this notice (a requirement of Medicare), to acknowledge that we have educated you regarding this benefit. This threshold is for outpatient services only. If it is determined that therapy is "not reasonable and necessary", you may be requested to pay out of pocket.

POSSIBLE REQUIRED DEDUCTIBLE:

Also, Medicare typically has an annual deductible of $198.00 before your benefits begin for the rest of the year. Some secondary insurances may cover this deductible, others will not. Therefore, we will assist you in identifying your financial responsibility and will need to collect this amount if required.

We will be closely monitoring our service so we can provide you with the highest quality care available.

Should you have any questions regarding any of this information, please do not hesitate to ask.

Thank you,

Shea Physical Therapy
Hand Therapy Services

Patient Signature _____ Date _____

SHEA PHYSICAL THERAPY
HAND THERAPY SERVICES
Medicare Patients

1. In the 2020 calendar year, have you received any of the following:

	Circle one	if yes, where?
physical therapy?	yes/no	
occupational therapy?	yes/no	
speech therapy?	yes/no	
home health services?	yes/no	
treatment at an outpatient facility?	yes/no	
seen at a doctor's office?	yes/no	

2. Have you had home assistance for:

	Circle one	if yes, by whom?
bathing?	yes/no	
household chores?	yes/no	
monitoring blood pressure?	yes/no	
administering injections?	yes/no	

3. Have you been hospitalized within the last 30 days? yes/no

   If yes, where?_____

   If yes, for what?_____

4. When did you receive any of these previous treatments or assistance?

   Start date_____ Last date treated _____

5. Are you currently receiving home health? yes/no

6. Is a nurse scheduled to see you? yes/no If yes, when?_____

Patient Signature_____Date_____

Witness_____Date_____